

## Women's Health Screening and Referral Program - Care Questionnaire

The Rhode Island Department of Health would like you to fill out this form while you wait. Your answers will help you and your provider identify services you may need and will help us plan new programs for women. Your answers will be confidential. If you have any concerns, please feel free to discuss it with your provider or call the Family Health Information Line at 1-800-942-7434.

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Are you trying to get pregnant? ☐ Yes ☐ No
2. Are you and your partner using birth control now? ☐ Yes ☐ No
3. What will you do if you are pregnant?  
☐ Keep the baby and raise a family with the father    ☐ Keep the baby as a single mother  
☐ Place the baby for adoption    ☐ Other    ☐ Don't know
4. Do you have health insurance? ☐ Yes ☐ No
5. If you are pregnant, do you have someone to help you? ☐ Yes ☐ No
6. Do you ALWAYS have heat, hot water, electricity, and access to a phone? ☐ Yes ☐ No
7. Have you skipped meals or eaten less because you do not have enough money for food? ☐ Yes ☐ No
8. Do you have any concerns about nutrition or diet? ☐ Yes ☐ No
9. Have you visited a doctor in the past year? ☐ Yes ☐ No
10. Do you have any medical or health problems? ☐ Yes ☐ No
11. Do you take a multi-vitamin with folic acid every day? ☐ Yes ☐ No
12. Do you have problems getting to the doctor because of transportation, child care, or other reasons? ☐ Yes ☐ No
13. Do you smoke? ☐ Yes ☐ No  
 If no, do you spend time with other smokers? ☐ Yes ☐ No
14. Do you drink beer, wine or hard liquor or use marijuana, cocaine, heroin, or other drugs? ☐ Yes ☐ No
15. Do you use condoms every time you and your partner(s) have sexual intercourse? ☐ Yes ☐ No
16. Have you or your partner(s) had Hepatitis, a **positive** HIV test, or AIDS? ☐ Yes ☐ No
17. At home, do you feel physically or verbally threatened or abused? ☐ Yes ☐ No
18. Do you feel depressed or have other mental health problems? ☐ Yes ☐ No
19. Did you ever have a serious complication with previous pregnancy or birth? ☐ Yes ☐ No
20. Did you ever deliver a premature baby, a sick baby or have a baby die? ☐ Yes ☐ No
21. Has anyone in your family or your partner's family had any birth defects, mental retardation or developmental delay? ☐ Yes ☐ No

### FOR OFFICE USE ONLY

Patient Number: \_\_\_\_\_ Service Site Number: \_\_\_\_\_

#### Positive Pregnancy Test ☐

- |   |  |
|---|--|
| <input type="checkbox"/> Prenatal Care      | <input type="checkbox"/> Home Visiting Program               |
| <input type="checkbox"/> Options Counseling | <input type="checkbox"/> Adolescent Self-Sufficiency Program |
| <input type="checkbox"/> Rite Care          |  |

#### Negative Pregnancy Test ☐

- |   |   |
|---|---|
| <input type="checkbox"/> Family Planning          | <input type="checkbox"/> Teen Prevention Program                              |
| <input type="checkbox"/> Preconception Counseling | <input type="checkbox"/> Other <input type="checkbox"/> No Referral Available |

☐ Home Visiting Program (+) ☐ Other (+/-) ☐ No Referral (-)

☐ Home Visiting Program (+) ☐ Community Action Program (+/-)

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|--|---|
| <input type="checkbox"/> WIC (+)               | <input type="checkbox"/> Community Action Program (+/-) |
| <input type="checkbox"/> Local Food Bank (+/-) | <input type="checkbox"/> Other (+/-)                    |

- |                                  |  |                                    |  |
|----------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> WIC (+) | <input type="checkbox"/> Nutrition Education (-) | <input type="checkbox"/> Other (-) | <input type="checkbox"/> No Referral (-) Available |
|----------------------------------|--|------------------------------------|--|

☐ Early Prenatal Care (+) ☐ Medical Provider (-)

☐ Early Prenatal Care (+) ☐ Medical Provider (-)

☐ Multivitamin (+/-) ☐ Folic Acid Education (+/-)

☐ Home Visiting Program (+) ☐ Other (-) ☐ No Referral (-) Available

<input type="checkbox"/> Tobacco Cessation Program (+/-)	<input type="checkbox"/> Tobacco Cessation Education (+/-)	<input type="checkbox"/> No Referral (-) Available
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<input type="checkbox"/> Substance Abuse Education (+/-)	<input type="checkbox"/> Substance Abuse Assessment (+/-)	<input type="checkbox"/> No Referral (-) Available
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☐ STD/HIV Education (+/-) ☐ HIV/STD Counseling/Testing (+/-)

☐ Early Prenatal Care (+) ☐ Medical Provider (-)

☐ Domestic Violence Hotline (+/-) 1-800-494-8100

☐ Mental Health Provider (+/-) ☐ No Referral (-) Available

<input type="checkbox"/> Early Prenatal Care (+)	<input type="checkbox"/> Preconception Counseling (-)	<input type="checkbox"/> No Referral (-) Available
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<input type="checkbox"/> Early Prenatal Care (+)	<input type="checkbox"/> Preconception Counseling (-)	<input type="checkbox"/> No Referral (-) Available
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<input type="checkbox"/> Genetics Counseling (+/-)	<input type="checkbox"/> No Referral (-) Available
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I give permission to release this information to the community referral agencies indicated above.

Please sign your name (voluntary): \_\_\_\_\_